News from the MOO arena....

ATTACHMENT A

(April 2007)

1) Q: The initial assessment visit is conducted to determine the immediate care and support needs of the patient. For Medicare patients, the initial assessment visit must include a determination of the patient's eligibility for the home health benefit, including homebound status. For patients receiving only nursing services or both nursing and therapy services, a registered nurse ***MUST*** conduct the initial assessment visit. When Physical therapy or speech therapy is the only service ordered by the physician, who must do the initial assessment?

   A: Per CFR 484.30 (a) If the physician orders only therapy services, it would be acceptable for the appropriate therapist to perform the initial evaluation visit. This does NOT mean that an HHA is precluded from having the RN perform all initial evaluation visits, if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Per CFR 484.55 (a) (2), when Physical therapy (PT) or speech language pathology (SLP) is the only service ordered by the physician, the PT or the SLP ***may*** complete the initial assessment visit.

2) Q: When initial orders exist for nursing and PT, can the PT make an evaluation visit and establish the start of care, with the RN subsequently visiting to conduct the initial assessment visit and to complete the SOC comprehensive assessment?

   A: No. When initial orders exist for nursing and PT, the Conditions of Participation require that the RN conduct the initial assessment visit to determine the immediate care needs of the patient, and for Medicare patients, to establish program eligibility including homebound status. The PT may conduct the PT evaluation visit after the initial visit by the RN.

3) Q: One of the time requirements outlined in the CoPs for the initial assessment visit is that it must be conducted "within 48 hours of referral". Does "referral" mean referral from a physician, or referral from anyone (e.g., the patient, family, assisted living facility)? Sometimes when an agency is contacted by the patient or family member, physician's orders for home care may not exist. Does the "clock" for the 48 hours start when the patient/family contacts the agency requesting services, or when the physician provides orders?

   A: "Referral" refers to the referral from a physician (or designee) for home care evaluation and/or services. The referral may come in the form of initial contact by the physician's office, a hospital discharge planner or even the patient or family member, who may be in possession of the written physician's orders for home care.

   If a patient or family member makes initial contact with the agency and has not discussed and/or received home care orders from the physician for a referral for home care, then this is not considered a "referral" for the purposes of determining compliance with conducting the initial assessment visit. In this case, the agency should contact the physician to obtain necessary orders, and then conduct the initial assessment visit within 48 hours of that referral, within 48 hours of the patient's discharge from an inpatient facility, or on the physician's ordered start of care date.

4) Q: If the patient is a therapy only patient but the agency's policy is that the RN does all the assessments, can the RN go in and start the comprehensive assessment before the therapist has seen the patient and started the care?

   A: In a therapy only case, either the PT or RN can perform the initial assessment and comprehensive assessment. Although it is more restrictive than required by federal guidelines, agency policy may require RNs to conduct initial assessment visits and/or comprehensive assessments on therapy only cases. The agency will be compliant with the Condition of Participation 484.55, Comprehensive Assessment of Patients regulation, as long as the RN does not complete the comprehensive assessment before the SOC

date; the date the PT delivers the first billable services. The RN may go in at 9 a.m. and complete the initial and comprehensive assessment for the patient as long as the therapist visits and delivers a billable service the same day, establishing the Start of Care. The RN's comprehensive assessment will not be valid if it is completed before the date the PT establishes the SOC.

5) Q: When calculating the days you have to complete the comprehensive assessment, the SOC is Day "0". At the other OASIS data collection time points, when you are calculating the number of days you have to complete an assessment, is the time point date, Day "0", e.g. for RFA 9, Discharge from Agency, the assessment must be completed within 2 calendar days of M0906, Discharge/trans/death date. Is M0906 Day "0"?

   A: Yes, when calculating the days you have to complete the comprehensive assessment, the SOC date is day "0". For the other time points the date of reference (e.g., transfer date, discharge date, death date) is day "0".

6) Q: We know the RN has 5 days from the SOC to complete the comprehensive assessment. Can the RN make a visit on Monday, LPN on Wednesday, and the RN finish the OASIS assessment on Friday?

   A: The SOC comprehensive assessment must be completed within 5 days after the SOC date. The SOC date is counted as day 0. If the clinician began the SOC on Monday, it must be completed no later than Saturday. Other disciplines may visit the patient and provide services after the initial assessment is completed and before the comprehensive assessment is completed.

7) Q: After SOC, say 2-3 weeks, the physician orders another discipline (Therapy). (The original orders were for skilled nursing only). We know a new OASIS need not be done unless the agency is going to a SCIC. Can the physical therapist do the f/u OASIS assessment? It is now a multidisciplinary case so does that mean that the OASIS has to be done by the SN?

   A: After SOC, agency policy may direct who completes the subsequent OASIS comprehensive assessments. In the scenario above, if the addition of the therapy services meets the agency's definition of a major decline or improvement in patient status, and if agency policy allows, the PT may perform the RFA 5, Other Follow-up assessment. The only time the RN is required to complete the initial and comprehensive assessment is at SOC when orders exist for nursing. An agency policy may direct that RNs complete all comprehensive assessments and in such cases, the RN must complete all assessments. This is not required, it is agency choice.

8) Q: Patient's primary pay source for skilled home care changes during the episode of care from Medicare to an alternate pay source. How do you do the OASIS?

   A: 1) If the original start of care date is maintained, continue assessments and OASIS data collection/reporting according to that date. Report any new pay source (or delete any that no longer pertain) in an update to M0150 – Current Pay Sources for Home Care or the Patient Tracking Sheet.

   2) If the start of care (SOC) date changes to coincide with the pay source change, the patient must be discharged (discharge date to coincide with last visit of "old" pay source). A new comprehensive assessment must occur with the new SOC date.

9) Q: Patient's primary pay source for home care changes during the episode of care – from other-than-Medicare to Medicare. How do you do the OASIS?

   A: This situation parallels response 2 in question #8 (above). Follow the actions described there (i.e., discharge patient on last visit of "old" pay source, conduct new comprehensive assessment at new SOC date). A SOC comprehensive assessment and OASIS data collection is required when Medicare becomes the payer source.

10) Q: A patient is seen at very infrequent intervals (e.g., every 30 days, every 60 days, every 90 days, etc.). What should be done about the every 60-day comprehensive assessment?

A: For Medicare & Medicaid patients, an assessment will need to be performed during the five-day period immediately preceding the end of each certification period. Visits scheduled on a monthly or every two-month basis usually can be scheduled into this period. A patient needing a skilled visit only every 90 days will require other arrangements. The visit will be reimbursed ***only*** if specifically ordered by the physician and considered to be reasonable, necessary, and a medically predictable skilled need. (The required assessment must occur in the presence of the patient, not be conducted over the telephone.)

11) Q: It is imperative that the assessing clinician be accurate on answering what the patient's status was on the "14th day prior to". Please explain the importance of the accuracy in determining the 14th day. What bearing does this have on the agency's outcomes/payment? Agencies sometimes tend to mark "unknown" and wonder if this is "hurting" their agency.

A: Prior status contributes to the Case Mix Report categories of "ADL Status Prior to SOC" and "IADL Status Prior to SOC" and is utilized in risk adjustment for some of the outcome measures. The "prior status" variables have proved to be particularly useful in risk adjustment for the OBQI reports, as they indicate the chronicity of a functional impairment (thus, impacting the patient's expected ability to improve in a specific outcome of interest).

The 14th day prior to SOC/ROC serves as a proxy for the patient's prior functional status. While it may not represent the "true" prior functional status, it allows the data collection of thousands of assessors to be standardized. General OASIS conventions state that data collectors should minimize the use of "unknown' as a response option, and to limit its use to situations where no other response is possible or appropriate. While under the current reimbursement for Medicare home care services, the "14 days prior" responses do not affect payment, since they do contribute to risk adjustment, under a Pay-for-Performance reimbursement model, an inaccurate (or inappropriately marked "unknown" response) may unfavorably affect agency reimbursement.

12) Q: What do we do if the agency is not aware that the patient has been hospitalized and then discharged home, and the person completing the ROC visit (i.e. the first visit following the inpatient stay) is an aide, a therapist assistant, or an LPN?

A: When the agency does not have knowledge that a patient has experienced a qualifying inpatient transfer and discharge home, and they become aware of this during a visit by an agency staff member who is not qualified to conduct an assessment, then the agency must send a qualified clinician (RN, PT, OT, or SLP) to conduct a visit and complete both the transfer (RFA 6) and the ROC (RFA 3). Both assessments should be completed within 2 calendar days of the agency's knowledge of the inpatient admission. The ROC date (M0032) will be the date of the first visit following an inpatient stay, conducted by any person providing a service under your home health plan of care, which, in your example would be the aide, therapist assistant, or LPN.

13) Q: The CoPs require that the comprehensive assessment be updated within 48hrs of the patient's return home from the hospital. The OASIS Assessment Reference Sheet states that the Resumption of Care assessment be completed within 2 calendar days of the ROC date (M0032), which is defined as the first visit following an inpatient stay. Does this mean that the ROC assessment (RFA 3) must be at least started within 48 hours of the patient's return home, but can take an additional 2 days after the ROC visit to complete?

A: No. When the agency has knowledge of a hospital discharge, then a visit to conduct the ROC assessment should be scheduled and completed within 48 hours of the patient's return home.

14) Q: What if an agency accidentally completed the RFA 4 – Recertification assessment early (on day 54) for a Medicare patient. Can the early assessment be used to establish the new case mix assignment for the upcoming episode?

A: Whenever you discover that you have missed completing a recertification for a Medicare patient within the required time frame (days 56-60), you should **not** discharge that patient and readmit, or use an assessment that was completed prior to the required assessment window. As soon as you realize that you missed the recert window, make a visit and complete the recertification assessment. You are out of compliance and will receive a warning from Haven or Haven-like software. Efforts should be made to avoid such noncompliance by implementing processes to support compliance with required data collection time frames.

15) Q: Do we mark response 1, Medicare (traditional fee-for-service) if the patient's payer is VA?

A: If the patient has both VA and Medicare and both are expected payers, then, you need to mark Response 1, Medicare (traditional fee-for-service) and Response 7, Other government (e.g. CHAMPUS, VA, etc.). But if the patient does not have Medicare, or Medicare is not an expected payer for provided services, then Response 7, Other government (e.g. CHAMPUS, VA, etc.) would be the correct response.

16) Q: If a patient is receiving Meals-on-Wheels services, do you capture the payment for the service as a Response 10; Self Pay on M0150 Current Payment Sources for Home Care?

A: No, food is not considered within the scope of M0150. Most patients pay for their food, whether they purchase it directly, a caregiver purchases and delivers it, or a service such as Meals-on-Wheels is utilized.

17) Q: When a patient is discharged from an inpatient facility in the last 5 days of the certification period, should M0175 on the Resumption of Care (ROC) assessment report inpatient facilities that the patient was discharged from during the 14 days immediately preceding the ROC date or the 14 days immediately preceding the first day of the new certification period?

A: When completing a Resumption of Care assessment, which will also serve as a Recertification assessment, M0175 should reflect inpatient facility discharges that have occurred during the two-week period immediately preceding the first day of the new certification period.

18) Q: Is an exacerbation of a disease considered a change in medical or treatment regimen for M0200, Medical or Treatment Regimen Change Within Past 14 days?

A: The exacerbation of a disease, in and of itself, would not be considered a change in medical or treatment regimen for M0200. The changes in medication, service, or treatment that might result from a new diagnosis or the exacerbation of disease would warrant a "Yes" response on M0200.

19) Q: If therapy or nursing or whatever discipline is involved, meets all goals and discharges the patient within 14 days of another discipline doing the ROC or DC OASIS, does this count as a service change for M0200? Or do you only count it if a patient's service is discontinued because they could not tolerate it for some reason? Also, are aide services considered in this OASIS question?

A: At discharge, M0200 is asking if the patient experienced a change in medical or treatment regimen in the 14 days prior to discharge. If multiple disciplines were involved in the care of the patient and one of those services changed or was discontinued in the 14 days prior to discharge, it would qualify as a change in service and be reported in M0200. The item does not ask why the change occurred, only whether or not a change occurred.

Health care services included for consideration in M0200 are those (health-related) activities delivered to a patient by a health care provider. If the home health aide services were health related, they would count for M0200.

20) Q: A patient is admitted to the hospital for knee replacement surgery. During the pre-surgical workup, a test result caused the surgery to be canceled. The patient only received diagnostic testing while in the

hospital but the stay was longer than 24 hours. Does this situation meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility?

A: No, under the circumstances described, the patient did not meet the OASIS transfer criteria of admission to an inpatient facility for reasons other than diagnostic testing, if the patient, indeed, did not have any other treatment other than diagnostic testing during their hospitalization. If the patient received treatment for the abnormal test result, then the situation, as described, would meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility.

21) Q: How do you determine diagnostic testing? I've been told before that cardiac catheterizations are not diagnostic procedures. Does the fact that the patient gets anesthesia make it a surgical procedure vs. diagnostic?

A: Diagnostic testing refers to tests, scans and procedures utilized to yield a diagnosis. Cardiac catheterization is often used as a diagnostic test to determine the presence or status of CAD. A cardiac catheterization is also used for treatment, once other testing has established a definitive CAD diagnosis. Each case must be considered individually by the clinician without making assumptions. Utilizing the definition of diagnostic testing, a clinician will be able to determine whether or not a certain procedure or test is a diagnostic test.

22) Q: When a patient has a G-tube (NG-tube, J-tube, and PEG-tube) and it is only utilized for medication administration, do you mark Response 3, Enteral nutrition for M0250)?

A: No, M0250 Response 3 captures the administration of enteral nutrition. Medication administration alone is not considered nutrition.

23) Q: When a patient has a feeding tube and it is only utilized for the administration of water for hydration (continuous or intermittent), do you mark Response 3, Enteral nutrition for M0250, Therapies?

A: No, M0250 Response 3 captures the administration of enteral nutrition. Hydration alone is not considered nutrition.

24) Q: A patient has a Hickman catheter and is receiving TPN over 12 hours. At the beginning of the infusion, the line is flushed with saline and at the end of the infusion, it is flushed with saline and Heparin. For M0250, do you mark both 1 and 2?

A: When the patient is receiving intermittent parenteral therapy at home and requires a pre- and post-infusion flush, it is not appropriate to mark Response 1, Intravenous or infusion therapy (excludes TPN), in addition to Response 2, Parenteral nutrition (TPN or lipids). The flushing of the line for intermittent parenteral therapy is considered a component of the parenteral therapy.

25) Q: For M0250, if a patient's appetite is poor and he/she has a g-tube and the physician orders "Ensure PRN through the g-tube", does this count as enteral nutrition for this OASIS item?

A: If a PRN order exists and the patient meets the parameters for administration of the feeding based on the findings from the comprehensive assessment, the assessing clinician would mark response 3. The clinician could not mark response 3 automatically when a PRN order exists at SOC because it is unknown if the patient will ever receive the enteral nutrition.

26) Q: My agency provides personal care services reimbursed by Medicaid to a patient that I am seeing for Medicare. Would the personal care services be considered "paid help" for M0350?

A: Responding to M0350 requires you to exclude any services that are being provided by your agency. Therefore, these personal care services would not be considered in responding to the item. If the personal care services were provided by another agency (or even provided by a friend or family member that is paid

by Medicaid or another source), it would be considered "paid help," because the services are not part of what your agency is providing to the patient.

27) Q: For M0390 how is vision evaluated for the patient who is too disoriented and cognitively impaired for the clinician to assess?

A: A caregiver may be able to assist by demonstrating the patient's response to an object that is familiar to him/her. Alternatively, this could be a situation where the patient is not able to respond, thus is nonresponsive (response 2).

28) Q: For M0400 an agency has a patient whose primary language is German, but he does speak English well enough for staff to generally communicate without the use of an interpreter. Often the staff may need to repeat their requests, or reword their statements, but he eventually adequately understands what they are asking or saying. When scoring M0400 Hearing and Comprehension of Spoken Language, they mark response "2" based on their assessment, but wonder if the patient's hearing/comprehension would be better (i.e., a response "0" or "1") if he were being spoken to in German, his primary language. Does the clinician have to assess the patient with an interpreter in order to score M0400 in the patient's primary language, even if the communication is generally adequate to allow evaluation of the patient's healthcare needs and provision of care outlined in the Plan of Care?

A: M0400 is an evaluation of the patient's ability to hear and understand verbal (spoken) language in the patient's primary language. If a patient is able to communicate in more than one language, then this item can be evaluated in any language in which the patient is fluent. If however, as is suggested in this scenario, your patient's ability to hear and understand is likely not as functional in a secondary language, you should make efforts necessary to access an interpreter to determine the patient's ability to hear and comprehend in the patient's primary language.

29) Q: My patient reports he cannot afford to buy his pain medications, and does have pain that occurs at least daily and interferes with quality of life issues. Can I say that the pain is not easily relieved because the patient does not have a means to relieve it?

A: Knowledge that the patient is not currently taking medications as prescribed due to financial concerns is certainly an important finding that should be documented in the drug regimen review portion of the comprehensive assessment and addressed in the plan of care. If the patient is not currently using adequate pain medication, for any reason, including inability to afford medications prescribed, M0430 should still be a reflection of the patient's current pain experience (<u>is</u> the pain easily relieved, <u>does</u> it occur at least daily, and <u>does</u> it affect one or more of the quality of life activities noted in the item.)

30) Q: My patient has post-op pain, which initially was well managed with pain medications. For the past few weeks the patient has been refusing to take her pain medications as prescribed due to fear of addiction. This has caused her to have pain that occurs at least daily and impacts her ability to sleep, get around her home, and carryout her home exercise program. Because the pain could have "easily" relieved her pain if she took her pain medications as prescribed, is this intractable pain?

A: The assessing clinician, with input from the patient will determine if the pain is easily relieved. In this scenario, it appears that this clinician feels the patient's pain could be easily relieved, but in reality it is not relieved due to a fear of addiction. M0430 should be a reflection of the patient's current pain and its current impact on the patient's life, given the current parameters, (e.g., pain level and characteristics, pharmacological and on-pharmacological treatments used). If the patient is not currently using adequate pain medication or non-drug pain management measures, even if they have been prescribed, and are present in the home, M0340 should still be a reflection of the patient's current pain experience (<u>is</u> the pain easily relieved, <u>does</u> it occur at least daily, and <u>does</u> it affect one or more of the quality of life activities noted in the item.)

31) Q: How can one OASIS tell whether a pressure ulcer has improved?

A: The OASIS items are used for outcome measurement and risk factor adjustment. There are NO outcome measures computed for pressure ulcer improvement. Descriptive documentation in the patient's clinical record should address changes in pressure ulcer size and status that show improvement. The National Pressure Ulcer Advisory Panel web site (http://www.npuap.org) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

32) Q: If a pressure ulcer has any eschar or slough AT ALL, is it considered non-observable and therefore unable to be staged, even if another portion of the ulcer reveals bone, indicating a stage 4 ulcer? The current guidance suggests that a pressure ulcer cannot be staged until the wound bed can be visualized, since any necrotic tissue may be covering a deeper wound depth than can be observed. But, when bone is visible, isn't it clearly a stage 4 pressure ulcer, regardless of what might be under any necrotic tissue present?

A: Based on guidance from the NPUAP and the WOCN Society, a pressure ulcer can only be staged when necrotic tissue is not present. Since CMS relies on the expert guidance from these organizations to support data collection for the pressure ulcer OASIS items, any pressure ulcer with any amount of eschar or slough present, even an ulcer with bone visible, would be considered non-observable and therefore could not be staged.

33) Q: According to the WOCN Guidance on OASIS Skin and Wound Status M0 Items, a "non-healing" status applies to a pressure ulcer with greater than or equal to 25% avascular tissue and Early/Partial Granulation status applies to a pressure ulcer with minimal avascular tissue (i.e. less than 25% of the wound bed is covered with avascular tissue). Does this guidance supersede the Chapter 8 M0464 guidance that states, "if part of the ulcer is covered by necrotic tissue then it is not healing (Response 3)?" What if only 5% of the wound bed is covered with eschar?

A: Follow the WOCN guidance. If only 5% of the wound bed is covered with eschar, according to the WOCN guidance, the status would be Early/Partial Granulation, as long as the other criteria are met. To meet the criteria for "Non-healing", the portion of the wound bed coverage must be equal to or greater than 25% avascular tissue.

34) Q: For M0470 is a venous stasis ulcer that is scabbed or encrusted counted as "observable"?

A: Any stasis ulcer should be counted unless a non-removable dressing covers it. A stasis ulcer that has a scab or crust or necrotic tissue should be counted.

35) Q: If a patient has a venous access device that no longer provides venous access, (e.g. no bruit, no thrill, unable to be utilized for dialysis), is it considered a venous access device that would be "counted" as a surgical wound for M0482, Surgical Wound and the subsequent surgical wound questions?

A: Yes, as long as the venous access device is in place, it is considered to be a surgical wound whether or not it is functional or currently being accessed.

36) Q: Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy?

A: The site of a peritoneal dialysis catheter is considered a surgical wound. The opening in the abdominal wall is referred to as the exit site and is not an ostomy.

37) Q: If a pressure ulcer or a burn is covered with a skin graft, does it become a surgical wound?

A: No, covering a pressure ulcer with a skin graft does not change it to a surgical wound. It remains a pressure ulcer. Applying a skin graft to a burn does not become a surgical wound. The burn remains a skin lesion, with details captured in the comprehensive assessment. In either case, a donor site, until healed would be considered a surgical wound.

38) Q: Does the presence of sutures equate to a surgical wound? For example, IV access that is sutured in place, a pressure ulcer that is sutured closed or a sutured incision around a fresh ostomy?

A: No, the presence of sutures does not automatically equate to a surgical wound. In the examples give, if the IV was peripheral, it would be excluded from M0440 and M0482, and a pressure ulcer does not become a surgical wound be being sutured closed, and the ostomy would be excluded from M0440 and M0482.

39) Q: Since an implanted venous access device is considered a surgical wound for M0482, when it is initially implanted, is the surgical incision through which it was implanted a second surgical wound (separate from the venous access device?)

A: No. The surgical incision is considered a surgical wound until it is healed, becoming a scar. The site of the venous access device is initially considered a surgical wound, as long as it is in place.

40) Q: If an abscess is incised and drained, does it become a surgical wound?

A: No, an abscess that has been incised and drained is an abscess, not a surgical wound.

41) Q: A venous access device is routinely accessed and upon assessment has a scab at the puncture site. Assuming there are no signs or symptoms of infection, is the wound status early/partial granulation or fully granulating?

A: To answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). Follow the Wound, Ostomy, and Continence Nurses' guidelines *(OASIS Guidance Document)* Found at http://wwwl.wocn.org/ to determine the status. Based on the WOCN guidelines, a wound with

- 25% avascular tissue is considered "non-healing"; therefore a venous access puncture site which is covered by a scab (avascular tissue) would be classified as Response 3 – non-healing.

42) Q: Is a midline PICC (inserted to about 20cm) considered a surgical wound or just a lesion?

A: A PICC, a peripherally inserted central catheter, is "Yes" for M0440, Skin Lesion or Open Wound, and "No" for M0482, Surgical Wound.

43) Q: What is the correct response to M0490 for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs.

A: Since the patient's supplemental oxygen use is not continuous, M0490 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be "4 – at rest (during day or night)". It would be important to include further clinical documentation to explain the patient's specific condition.

44) Q: Would "Lifeline" be a service that would be included in answering M0350?

A: Lifeline is a service that provides assistance to the patient and would be included in responding to M0350. Such services are typically paid for by the patient, family or a specific program (e.g., a non-agency community program), and in such cases would be reported as response 3 – Paid help.

45) Q: When responding to M0 570 & 580 what does unresponsive mean?

A: It means the patient is unconscious, or is unable to voluntarily respond. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered unresponsive. A patient with language or cognitive deficits is not automatically considered "unresponsive". A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away form bright lights, or by attempting to remove an uncomfortable clothing item or bandage. A patient who simply refuses to answer questions should not automatically be considered "unresponsive". In these situations, the

clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview.

46) Q: In the grooming items how do you answer the OASIS item if a handicap person has everything in their home adapted for them? For example, their closet shelves & hangar racks are lowered so they can reach in a wheelchair. Is this type of patient independent in grooming?

A: M0640, Grooming, Response 0 indicates a patient is able to safely groom self unaided, with or without the use of assistive devices or adapted methods. At the assessment time point, if the patient is able to safely access grooming aids, mirror and sink, and perform a majority of the most frequently performed grooming tasks (washing face and hands, hair care, shaving/make-up, teeth/denture care and fingernail care), then Response 0 would be appropriate even if the patient is using adaptive equipment and the home had special modifications to enable independence.

47) Q: Is hair washing/shampooing considered a grooming task, a bathing task, or neither?

A: The task of shampooing hair is not considered a grooming task for M0640. Hair care for M0640 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M0670, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items.

48) Q: If a patient was in the hospital 14 days prior to the OASIS data collection time point and hospital policy prevents the patient from managing their own medications, how do you respond to the patient's prior ability to manage their oral medications?

A: To answer the prior status items correctly, interview the patient/caregiver and determine what the patient's ability was on that particular day, despite the facility's policies or restrictions. The patient's cognitive, mental and physical condition on that particular day must be considered when determining the accurate response. Assessments of the patient's vision, strength and manual dexterity in the hands and fingers, as well as mental status will provide the necessary information to evaluate his/her ability.

49) Q: A patient can retrieve her clothing independently & can perform all upper body dressing tasks independently & safely except for putting on her bra (for which she requires assistance). How should I report her upper body dressing status?

A: When a patient's ability varies among the multiple tasks included in an activity such as upper body dressing, the response should indicate the patient's ability on the majority of the tasks included. This patient's ability would be marked as Response "0".

50) Q: If the patient has a physician's order to wear elastic compression stockings and they are integral to their medical treatment, (e.g., patient at risk for DVT), but the patient is unable to apply them, what is the correct response for M0660?

A: M0660 identifies the patient's ability to obtain, put on, and remove their lower body clothing, including lower extremity supportive or protective devices. A prescribed treatment that is integral to the patient's prognosis and recovery from the episode of illness, such as elastic compression stockings, air casts, etc., should be considered when scoring M0660. The patient in this situation would be scored based on their ability to obtain, put on and remove the majority of their lower body dressing items as the elastic compression stockings are a required, prescribed treatment.

51) Q: For M0670, even the normal person requires a long-handled sponge or brush to wash their back. However, we have been instructed that if a patient can do everything except wash their back & requires a long-handled sponge or brush they would be marked as a "1". Please explain.

A: Assistive devices promote greater independence for the user be enabling them to perform tasks they were previously unable to, or had difficulty safely performing. The intention of the use of the term "devices" in the response for M0670 is to differentiate a patient who is capable of washing his entire body in the tub/shower independently (response 0), from that patient who is capable of washing his entire body in the tub/shower only with the use of (a) device(s). This differentiation allows a level of sensitivity to change to allow outcome measurement to capture when a patient improves form requiring one or more assistive devices for bathing, to a level of independent function without

devices. Individuals with typical functional ability (e.g. functional range of motion, strength, balance, etc.) do not "require" special devise to wash their body. An individual may choose to use a device (e.g., a long handled brush or sponge) to make the tasks of washing the back or feet easier. If the patient's use of a device is optional (e.g., it is their preference, but not required to complete the task safely), then the score selected should represent the patient's ability to bath without the device. If the patient requires the use of the device in order to safely bathe, then the need for the device should be considered when selecting the appropriate score. CMS has not identified a specific list of equipment that defines "devices" for the scoring of M0670. The clinician should assess the patient's ability to wash their entire body and use their judgment to determine if a device, assistance, or both is required for safe completion of the included bathing tasks.

52) Q: If a patient uses the tub/shower for storage is this an environmental barrier? Is the patient marked a "4" in M0670?

A: Upon discovering the patient is bathing at the sink, the clinician should evaluate the patient in attempts to determine why he/she is not bathing in the tub/shower. If it is the patient's personal preference to bathe at the sink (e.g. "I don't get that dirty", "I like using the sink."), but they are physically and cognitively able to bathe in the tub/shower; the clinician will pick the response option that best reflects the patient's ability to bathe in the tub/shower. If the patient no longer bathes in the tub/shower due to personal preference and has since begun using the tub/shower as a storage area, the patient would be scored base on their ability to bathe in the tub/shower when it was empty. If the patient has a physical or cognitive/emotional barrier that prevents them from bathing in the tub/shower and therefore has since starting using the tub/shower as a storage area, the clinician will score the patient as "4 – Unable to use the shower or tube and is bathed in bed or bedside chair, unless they are a "5" unable to participate in bathing and is totally bathed by another person. Note that the response of "4" (or"5") is due to the patient's inability to safely bathe in the tub/shower (even with help) due to the physical and/or cognitive barrier, not due to the alternative use of the tub for storage.

53) Q: Is it true that thoracostomies and nephrostomies are excluded as lesions or surgical wounds because they are "ostomies"? However, surgical wounds are described as any wounds with drains. Wouldn't you say a thoracostomy (chest tube) & nephrostomy are wounds with drains?

A: This topic is under further review by CMS. When new guidance is available, it will be shared with the providers.

54) Q: A patient is overtly depressed for years; no change is expected. He/she does minimal ADLs due to the depression. Would you mark M0610 "2" and M0620 "5"?

A: M0610 is asking the clinician to report whether one of the listed behaviors were observed or reported to have occurred at least once a week. These behaviors, per the OASIS Web-Bases training, represent more sever manifestations of alterations in cognitive or neuro/emotional status and have serious implications for care and care planning. Response 2 is selected when the patient has impaired decision- making that occurs at least once a week. The clinician needs to assess whether or not the patient's performance of minimal ADLs is due to impaired decision making. There are many reasons why a patient might perform minimal ADLS (e.g., laziness, limited ROM, pain) that would not qualify as impaired decision making for M0610. If the clinician believes the depression has impaired the patient's decision- making ability and therefore ADLs are only minimally performed, causing serious implications for care and care planning, then Response 2 may reflect an appropriate response for the patient's assessment.

M0620 is asking the clinician to report the frequency of reported or observed behavior problems that are of concern for the patient's safety or social environment. Again, it will be the decision of the assessing clinician to determine if the patient's behavior meets this description and should be reported in M0620.

55) Q: Recent clarification reveals that the transfer in/out of the tub/shower should not be included in the scoring of M0670. Previous guidance also stated that in order for the patient to be able to bathe in the tub/shower they had to be able to get there (e.g., if a patient is restricted from stair climbing and their only tub/shower is upstairs, then they are unable to bathe in the tub/shower). Is this still true or is M0670 limited to just the patient's ability to wash their entire body once in the tub/shower? It seems strange that walking up the stairs *would* impact the bathing item score, but getting into the tub/shower *wouldn't.*

Guidance for this item has evolved over time and additional clarification has been provided, allowing objective measurement of improvement in a specific portion of the bathing process; the patient's ability to wash their entire body. If a patient can get to the tub/shower and in/out of the tub/shower (by any safe means), then their ability to wash their

entire body while in the tub/shower should be assessed. If medical restrictions prohibit the patient from activities which would be required for the patient to get to/from the tub/shower (e.g., restricted stair climbing), and in/out of the tub/shower (e.g., some joint precautions), or from bathing or showering in the tub/shower (e.g., some cast or incision precautions), then the patient should be considered "unable to bathe in the tub or shower" and would be scored a "4" or '5", depending on their ability to participate in washing their entire body at any location outside of the tub/shower.

56) Q: A male patient uses the toilet during the day independently, but it is determined that it is unsafe to use it at night so he uses a urinal. He is probably able to use the commode but does not have one & being a male it's more practical to use the urinal. Would he be scored as a "2" or "3"?

A: When determining the correct response for M0680, Toileting, the clinician chooses the response that reflects what the patient is able to do safely. If the patient's ability varies during the assessment time frame, select the response that reflects the patient's usual status, (more than 50% of the time) during the day of the assessment. The assessing clinician should determine if the patient's usual ability during the day of assessment is that he is able to safely use the toilet, or that his usual status is that he is unable to get to and from the toilet and his usual status is that he is able to use the urinal. Clinicians should be careful not to assume that a patient will suddenly (or ever) become able to safely use a bedside commode, if one is obtained for this use. Observation is the preferred method of data collection for the functional items, and the most accurate assessment will include observations of the patient using the device. Often safe use will require not only obtaining the device, but also appropriate selection of specific features, fitting of the device to the patient/environment and patient instruction in its use.

57) Q: If a patient uses a bedside commode because their bathroom is not adapted for wheelchair; i.e., they could get to and from the bathroom but the door isn't wide enough for the wheelchair, does that make them a #2 for M0680?

A: Per CMS more information would need to be known in order to answer this question. M0680, Toileting, reports the patient's ability to safely get to and from the toilet with or without a device. Is the patient chair fast and unable to ambulate? If so, and if he is not able to the wheelchair to the toilet due to an environmental barrier, then he is unable to get to and from the toilet and would be a "2", if able to use a bedside commode. If the patient is ambulatory, when assisted or supervised by another person, can they safely get to and from the toilet (from the wheelchair left outside the bathroom door)? If so, Response 1 would be the appropriate response.

58) Q: If a patient can take the majority of their medications (vitamins, stool softeners, etc.) but cannot remember to take their digoxin, does that still make them independent with the majority of their medications even though we know how important the digoxin is?

A: If a patient's ability varies among the tasks included in a single OASIS item (like M0660 lower body dressing, or M0780 Oral Medications), select the response that represents the patient's status in a "majority" of the tasks. The concern regarding the importance of the digoxin focuses on critical issues that need to be addressed in the plan of care. You must understand that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g., the percentage of medications a patient can independently take). Less objective criteria, like which medications are more important, or which lower body dressing items are more important than others, have limitations in consistency in which a similar situation would likely be interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OAIS accurately and the agency's outcome data will be standardized comparison between other agencies. In any situation where the clinician is concerned that OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail, which is required for a comprehensive patient assessment.

59) Q: Is C-PAP *without* oxygen or a nebulizer included as equipment for M0810 and M0820?

A: No. If the patient's only equipment was c-PAP without oxygen or a nebulizer, the correct M0810 response would be NA – No equipment of this type used in care and M0820 would be skipped.

60) Q: Our agency is continuing with voluntary OASIS data collection for skilled private insurance patients. Some of

our private insurance payers are using a reimbursement model similar to the Medicare PPS, which requires a response for M0825 of "0" or "1". Although the assessment strategies in Chapter 8 of the OASIS Manual instruct us to mark "NA" for non-Medicare patients, would we be non-compliant to mark "0" or "1" for non-Medicare patients instead of "NA"?

A: No, the response to M0825 only affects the Medicare PPS when M0150 is marked "1 – Medicare (traditional fee for service), therefore marking "0" or "1" for non-Medicare patients is an acceptable agency practice.

61) Q: If nursing and therapy are ordered, is there any requirement that the completion of the comprehensive assessment be delayed until the therapy evaluation(s) are completed in order to determine a response for M0825 Therapy Need, and the primary or secondary diagnoses?

A: The CoPs require the SOC comprehensive assessment be completed on or within 5 days after the SOC date. Evaluations by other disciplines (e.g., therapies) are required to occur in a timely manner consistent with patient needs and professional standards of practice. For multidisciplinary cases, there is no explicit requirement that the therapy evaluation(s) be conducted prior to completion of the SOC assessment b the RN, although agencies should realize that the additional information gained form the completion of therapists' evaluations may contribute to a greater accuracy for therapy need for M0825 and may influence the selection of the primary diagnosis.

62) Q: We have a rather large physician's practice in our area where no appointments are scheduled in advanced. The patients needing to be seen simply are instructed to show up and are seen by the physician's on first-come, first-served bases. Since all these appointments are "unscheduled", would all of these doctor's visits need to be reported as emergent care by the MD on M0830?

Since the determination of an MD emergent care visits is defined as a visit to/from the MD scheduled less than 24 hours in advance, then the patient's visits to the MD scheduled and provided as you describe would all meet the definition of being scheduled less than 24 hours in advance, and should be reported as emergent care Response 2 for M0839 – Emergent Care.

63) Q: An RN completes a SOC assessment and establishes the plan of care. After the admission visit, the LPN and home health aide provides subsequent care for a period of 2 weeks, during which time the patient is seen in the ER. The physician contacts the agency to discontinue home care without an opportunity to complete a discharge assessment visit. Based on current guidance, in this case of an unexpected discharge, the discharge comprehensive assessment would be based on the last visit by a qualified clinician (which was the SOC assessment by the RN). Since it should reflect the patient's status on that SOC visit, should the emergent care use be captured, since it occurred after the SOC visit?

A: No, in the case of an unexpected discharge, the agency must go back to the last visit that was completed by a qualified clinician, and report the patient's health status at that actual visit, and would not capture events or changes in patient status/function (improvements or declines) that occurred after the last visit conducted by a qualified clinician. Agencies should recognize that the practice of allowing long periods of time where the patient's care is provided by those unable to conduct a comprehensive assessment may negatively impact the patient's care and outcomes, and, in fact, in a situation as the one described, may be the reason that the patient required emergent care.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services.